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RECOMMENDATIONS FOR SUPPLEMENTARY FUNDING FOR PROGRAMMES IN THE AFRICA REGION WITHOUT RECOMMENDATIONS FOR FUNDING FROM GENERAL RESOURCES*

SUMMARY

The present document contains recommendations for supplementary funding for countries in the Africa region for which no recommendations for funding from general resources are requested at the 1993 Executive Board session. The programme proposals submitted here are aimed at expanding or complementing ongoing programmes in the countries concerned. The Executive Director recommends that the Executive Board approve supplementary funding in the following amounts for the programmes listed below, subject to the availability of specific-purpose contributions.

Country/programme	Amount (United States dollars)	Duration
Côte d'Ivoire	1 243 000	1993-1996
Guinea	725 000	1993-1995
Zimbabwe	9 289 000	1993-1996

Summaries of individual recommendations follow. A table setting out the planned annual phasing of expenditure for each supplementary funding proposal is given at the end of the document.

* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programmes cooperation at the end of 1992, will be contained in the "Summary of 1993 recommendations for general resources and supplementary funding programmes" (E/ICEF/1993/P/L.2 and Add.1).

I. CÔTE D'IVOIRE

Basic data (1991 unless otherwise stated)

Child population (millions, 0-15 years)	7.4
U5MR (per 1,000 live births)	127
IMR (per 1,000 live births)	93
Underweight (%, moderate and severe)	12
Maternal mortality rate (per 100,000 live births)	..
Literacy (% male/female, 1990)	52/32
Primary school enrolment (%, net, male/female, 1990)	58/42
Percentage of grade 1 reaching grade 4 (1988)	78
Access to safe water (%, 1990)	76
Access to health services (%, 1980)	30
GNP per capita	$690

One-year-olds fully immunized against:

tuberculosis:	63 per cent (1990)
diphtheria/pertussis/tetanus:	48 per cent (1990)
measles:	42 per cent (1990)
poliomyelitis:	48 per cent (1990)

Pregnant women immunized against:

tetanus:	63 per cent (1990)

Making health facilities "baby-" and "mother-friendly"

1. In 1992, the Executive Board approved a primary health care (PHC) programme for the period 1992-1996 as part of the country programme of cooperation for the Côte d'Ivoire (E/ICEF/1992/P/L.9). The programme addresses the development of PHC using the Bamako Initiative strategy and the gradual integration of expanded programme of immunization (EPI) and control of diarrhoeal diseases (CDD) activities over the period of the programme to reduce infant and child mortality and malnutrition. The PHC programme foresaw focused activities in six rural health zones and included a strong social mobilization element as well as monitoring and evaluation.

2. Although the Côte d'Ivoire has among the highest gross national product (GNP) per capita in the West Africa region, at $690, health indicators remain poor. The infant mortality rate (IMR) is 93 per 1,000 live births and the under-five mortality rate (U5MR) is 127 per 1,000 live births. The principal causes of child mortality are acute respiratory infections (ARI), measles, diarrhoea, anaemia, malaria and neonatal tetanus. Maternal mortality is estimated to be very high at 840 per 100,000 live births, with the main causes being haemorrhage, infections and obstetrical complications. Moreover, acquired immune deficiency syndrome (AIDS) is an increasing concern, with 5 to 10 per cent of the population being seropositive for the human immunodeficiency virus (HIV).

3. The Côte d'Ivoire made substantial investments in its health system in the past, particularly in the training of medical and paramedical personnel, as well as in the building of infrastructure. However, basic health care coverage for women and children remains poor as illustrated by still low immunization coverage (39 per cent for measles in 1992) and high mortality rates of young children. The inefficiency of the heal h system can be explained by the lack of adequate resources, owing partially to the decrease in the Ministry of Health operating budget. Even more serious is the poor management of existing resources and the lack of integration of different services. This results in low accessibility to health care for inhabitants of rural areas; low utilization of the system due to the poor attitude of the health care providers and poor quality of services (especially for maternal and child health (MCH) services). Other problems include the lack of budgets for drugs, inconsistent and unnecessary drug prescriptions caused by the absence of an essential drugs policy, and a non-functioning referral system.

4. The Ministry of Health, with the support of UNICEF and other agencies such as the Fonds d'aide et de coopération aux Etats de la communauté (Fund for aid and cooperation to countries of the former French community in West Africa) and the World Bank, has started to reorganize the public health system, emphasizing PHC activities in rural areas and reinforcing safe motherhood activities at the referral level. UNICEF support to PHC in six rural health zones includes the provision of essential drugs, the rationalization of health care services, community financing and community participation.

5. In 1991, the Côte d'Ivoire agreed to stop the distribution of free or low-cost infant formula in health facilities as one of the first test cases of a new agreement signed in 1991 with the World Health Organization (WHO) and UNICEF. The Government of the Côte d'Ivoire, together with WHO and UNICEF, has been taking active steps to implement the "baby-friendly" hospital initiative using the WHO/UNICEF publication "10 steps for successful breast-feeding" as a guide. By February 1992, four hospitals (including two university teaching hospitals) had achieved "baby-friendly" status as established by the WHO/UNICEF guidelines.

6. The evaluation of the pilot phase of the "baby-friendly" hospital initiative has shown how breast-feeding promotion was perceived positively by health personnel, as the proposed intervention was reinforcing the positive cultural aspects (such as rooming-in and support to human bonding) rather than underscoring the weaknesses of public health institutions. The initiative was also enthusiastically endorsed by the Ministry of Health, which wishes to go to scale rapidly in transforming all 86 hospitals in the Côte d'Ivoire to "baby-friendly" hospitals. However, public health authorities expressed their concern about isolating breast-feeding promotion from other child survival, protection and development activities and also from activities to support the well-being of women in general, arguing that hospitals where mothers die from haemorrhage and children from dehydration or measles could not be reasonably qualified as "baby- (or mother-) friendly".

7. This proposal, therefore, is designed to enhance and extend the current PHC programme to implement the WHO/UNICEF policy in support of breast-feeding on a national scale and to reinforce child survival, protection and development and safe motherhood activities at referral facilities and in urban areas not

already covered by the PHC programme. The proposal seeks to improve the effectiveness of health services through strengthening training and supervision activities at all levels using breast-feeding promotion and safe motherhood activities as an entry point, and by strengthening structures of participation and empowerment for improved household utilization of health activities.

8. This expanded PHC programme will aim to reduce low birth weight to below 10 per cent; reduce infant and under-five deaths due to malaria by 20 per cent; and reduce maternal mortality due to infections by 75 per cent, due to dysgravidia by 30 per cent and due to haemorrhages by 20 per cent. Among pregnant women, the expanded PHC programme aims to reduce anaemia from 60 to 30 per cent and to reduce the prevalence of sexually-transmitted diseases (STDs) from 40 to 5 per cent. The two main components of the proposal are activities to strengthen the health system and support to increasing access and use of health facilities by the poor in urban areas.

Strengthening the capacity of the national health system

9. The expanded PHC programme will support policy development for breast-feeding and safe motherhood at the central level, with mobilization activities to disseminate these policies through seminars for health workers and through the mass media for the general public. At the health facility level, standardized procedures and practices will be introduced in the areas of child survival, protection and development and safe motherhood, reinforced by training, improved supervision and the supply of basic equipment and essential drug kits. These activities within the formal health system will be complemented by the establishment of breast-feeding support groups in communities and the dissemination of information on safe motherhood to young women through women's groups and schools.

"Baby-" and "mother-friendly" urban health facilities

10. The current PHC programme explicitly addresses the priority needs of the rural areas of the Côte d'Ivoire. However, there are some emerging health problems related to increased urbanization (40 per cent of the population of the Côte d'Ivoire lived in urban areas in 1992) which are threatening mothers and young children. The decline in breast-feeding (in Abidjan, only 42 per cent of women continue breast-feeding for at least six months) is responsible for a large number of cases of diarrhoea and malnutrition. The increased transmission of AIDS is facilitated by the high rate of STDs among the total population (40 per cent of pregnant women reporting to health facilities have STDs), especially among migrant populations concentrated in the peri-urban slums.

11. The expanded PHC programme will focus on urban facilities in six towns associated with the six rural health zones supported in the current PHC programme and also on model "baby-" and "mother-friendly" facilities in two extremely poor communes close to Abidjan. In all these facilities, support will be given to staff to use the assessment-analysis-action (triple A) approach to review and plan for improvement in the delivery of health services, focusing on breast-feeding and safe motherhood. Through training, linkages with universities and other local institutions, clarification of national policy, collaboration with urban social workers and the creation of mother

support groups, the new approach will achieve the PHC objectives in the targeted areas. A total of 16 hospitals and 38 urban health facilities are targeted for improvement by 1996, with the training of over 240 health care providers. At least 16 community support groups will be formed, and information, education and communication (IEC) materials will be produced to distribute concise messages to the community (especially to young urban women) on safe motherhood and breast-feeding. These activities will complement support being provided to the health sector in the Côte d'Ivoire by the United States Agency for International Development for family planning, by the Governments of Germany and Japan for surgical equipment for obstetric referral facilities, and by the European Community for essential drugs.

12. Supplementary funding in the amount of $1,243,000 is requested for the period 1993-1996 to support the above activities.

II. GUINEA

Basic data (1991 unless otherwise stated)

Child population (millions, 0-15 years)	3.3
U5MR (per 1,000 live births)	234
IMR (per 1,000 live births)	138
Underweight (%, moderate and severe)	..
Maternal mortality rate (per 100,000 live births)	559
Literacy (% male/female, 1990)	35/13
Primary school enrolment (%, net, male/female, 1990)	34/17
Percentage of grade 1 reaching grade 4 (1988)	69
Access to safe water (%, 1990)	52
Access to health services (%, 1980)	75
GNP per capita	$450

One-year-olds fully immunized against:

tuberculosis:	53 per cent (1990)
diphtheria/pertussis/tetanus:	35 per cent (1990)
measles:	90 per cent (1990)
poliomyelitis:	33 per cent (1990)

Pregnant women immunized against:

tetanus:	25 per cent (1990)

13. In 1991, the Executive Board approved an education for all programme for the period 1991-1995 (E/ICEF/1991/P/L.8) as part of the country programme of cooperation for Guinea. This proposal is designed to enhance the current education for all programme to accelerate implementation of basic education for all in Guinea. Since the World Conference on Education for All in Jomtien, Thailand, in March 1990, heightened national interest in education has opened possibilities for accelerating implementation of education for all. This enhanced programme will build on these developments. It will also take into account lessons learned from innovative approaches attempted by the Government of Guinea to respond to the Jomtien challenges since the launching of the 1991-1995 programme. The proposed programme will address specifically the objectives of increasing school enrolment rates, particularly for girls; reducing drop-out rates; and reducing illiteracy.

14. The country covers an area of 246,000 square kilometres, with an estimated population of 5.8 million. Approximately 70 per cent of the population are under 35 years of age. It is estimated that in the year 2000, Guinea will have approximately 1,470,000 children between the ages of 7 and 9 years, or 16.5 per cent of the country's total population. It is further estimated that by the year 2000, Guinea will have approximately 1,000,000 children between the ages of 9 and 15 years, a large proportion of them being girls, who will have left school or who will have never been enrolled in school for various reasons.

15. The current country programme of cooperation began in the midst of an economic crisis that has sharply decreased government investment capacity. Although blessed with natural resources, including mineral deposits and climatic and soil conditions favourable for farming, Guinea is one the poorest countries in the world, with a GNP per capita of $450 in 1990. The Government, which has been under a structural adjustment regime negotiated with the International Monetary Fund since 1987, has failed to live up to all of the conditions of the agreement, such as privatization and the reduction of the civil service. A new agreement, called the Enhanced Structural Adjustment Facility Agreement, signed in 1991, requires the country to further trim the size of the civil service, continue the privatization programme, reduce public utility subsidies and respect promises of budgetary expenditure restraint.

16. Despite its financial constraints, the Government is keenly aware of factors that limit the development of basic education and is eager to address them. In September 1989, a national education plan was adopted, and following the Jomtien conference the Government committed itself to meet the challenge of providing basic education for all the Guinean people.

17. Factors that negatively affect the education system in Guinea include:

(a) The insufficient infrastructure for basic education which prevents most children from having access to school. In 1987, only 35 per cent of school-age children were enrolled nationwide (54 per cent in urban areas and 17 per cent in rural areas). In 1990-1991, enrolment increased by only 2 to 3 per cent;

(b) The quality of education suffers from a lack of basic equipment, supplies and didactic materials, as well as a limited number of trained and qualified teachers.

18. These constraints have caused a continued fall in enrolment rates throughout the country (31 per cent in 1984-1985 compared to 28 per cent in 1987-1988); a high drop-out rate, particularly of girls living in rural areas; and ultimately a high illiteracy rate (74 per cent of the population), particularly among girls and women for whom this rate reaches 86 per cent.

19. The present project aims to improve basic education quantitatively and qualitatively. The specific quantitative objectives are:

(a) To contribute to national efforts to increase enrolment rates of school-age children by 15 per cent per year;

(b) To contribute to national efforts to increase enrolment levels in functional literacy programmes by 15 per cent per year for parents, particularly mothers, and young girls;

(c) To contribute to national efforts to promote and reinforce community-based and affordable services at the preschool level, which will increase the chances for healthy growth as well as physical and psychological preparation for school of 50 per cent of children between the ages of 3 and 5 years.

20. The qualitative objectives are:

(a) To improve teaching conditions by reducing the teacher/student ratio and by preparing effective learning materials;

(b) To provide training for introducing appropriate methods and activities at preschool centres;

(c) To develop non-formal educational approaches for young people who have dropped out or have never attended school, particularly young girls.

21. The above objectives will be met through the following:

(a) The establishment of functional literacy and basic education programmes for adults, especially for women and girls;

(b) The development and establishment of education programmes for out-of-school children at the "Djamaa centres" (community schools or "schools for a second chance");

(c) The development and establishment of community-based early childhood and development programmes.

Djamaa centres or "schools for a second chance"

22. Based on a recently conducted feasibility study, UNICEF will support collaboration between interactive rural radio education programmes and the Djamaa centres. The aim is to carry out an experimental programme of basic education for about 30,000 children who are not enrolled in school. At least 1,500 young people currently without work will be involved in this activity.

Community-based early childhood and development

23. UNICEF will assist the Government, on one hand, to define and adopt a national plan for community-based early childhood development and, on the other hand, to establish 20 experimental community-based early childhood and development centres. This assistance will include support for the training of 40 new rural animators and 20 supervisors at regional management units; the production of didactic materials; and the provision of equipment and materials to the technical agents in charge of the management of the centres and supervision of trainers.

Functional literacy for women

24. UNICEF will provide support to introduce literacy and social education programmes at 100 newly established women's centres, which will be strategically chosen to allow them to be fully utilized by women's organizations, cooperatives and groups. Approximately 15,000 women and girls (between 4,000 and 5,500 per year) will be trained at these centres in three years. UNICEF assistance will facilitate the training of 72 trainers of the national literacy service, technical services and non-governmental organizations (NGOs). These trainers will in turn provide appropriate supervision and follow-up at the Djamaa centres. The project will also train 200 permanent trainers who will carry out literacy and post-literacy programmes to prevent recedivism among Djamaa centre trainees. UNICEF assistance will include the provision of teaching materials and mobile audiovisual equipment.

25. Supplementary funding in the amount of $725,000 is requested for the period 1993-1995 to support the above activities.

III. ZIMBABWE

Basic data (1991 unless otherwise stated)

Child population (millions, 0-15 years)	5.4
U5MR (per 1,000 live births)	88
IMR (per 1,000 live births)	61
Underweight (%, moderate and severe)	12
Maternal mortality rate (per 100,000 live births, 1988)	77
Literacy (%, male/female, 1990)	74/60
Primary school enrolment (%, net, male/female)	../..
Percentage of grade 1 reaching grade 4 (1988)	84
Access to safe water (%, 1990)	84
Access to health services (%, 1988)	85
GNP per capita	$620

One-year-olds fully immunized against:

tuberculosis:	91 per cent
diphtheria/pertussis/tetanus:	89 per cent
measles:	87 per cent
poliomyelitis:	88 per cent

Pregnant women immunized against:

tetanus:	51 per cent

Support for child mortality reduction strategies

26. Child health has markedly improved in Zimbabwe since the country gained experience. However, IMR and U5MR are still high in comparison with many other countries. Present circumstances indicate that, without additional resources, the gains made until now may well be reversed and further reductions in infant and child mortality rates will be difficult to achieve due to drought, the social impact of the economic structural adjustment programme, inflation and AIDS.

27. The current devastating drought has cost the Government about $400 million on unplanned food imports to meet priority needs. This amount is almost three times the country's entire health budget for 1992, including the emergency child feeding programme. Even if the drought ends soon, its economic impact will be felt for some time.

28. Although the Government increased the health budget by 22 per cent this year under the economic structural adjustment programme, a 45 per cent inflation rate and the recent devaluation of the currency have reduced the real value of the health budget and raised prices, especially for supplies and equipment purchased from abroad. Over the last two years, real per capita expenditure for health dropped by 25 per cent, the lowest in five years.

29. In the past few years, the number of AIDS deaths among children has been rising. Sentinel surveys at antenatal clinics have estimated that in some areas up to 130 children per 1,000 live births may die of AIDS by their fifth birthday.

30. Due to all these factors, Zimbabwe will need a substantial increase in assistance in the health sector in the next three to four years. The Ministry of Health has recently completed its five-year plan for the period 1992-1996, with an emphasis on further improving MCH services.

31. The overall objective is to contribute towards achieving the goals of the World Summit for Children and the Zimbabwe National Programme of Action for children by reducing under-five and infant mortality and morbidity and enhancing proper child development in a sustainable manner. The major goals for children in the 1990s are to reduce IMR to about 40 per 1,000 live births and U5MR to about 50 per 1,000 live births.

32. The specific objectives of this project, which will run from July 1993 to June 1996, will be to achieve the EPI disease reduction goals; to reduce mortality from ARI, diarrhoea and malaria by one third; and to reduce perinatal and neonatal mortality by half. In order to achieve those objectives, the project will:

(a) Strengthen community-based health activities and community involvement in health care;

(b) Strengthen government capacity to reallocate existing resources for priority basic health programmes and use resources in the most cost-effective approaches to health care delivery;

(c) Assist the Government, NGOs and the private sector to identify ways of generating additional resources for basic health care.

33. The overall strategy will include the following elements:

(a) To empower families with relevant knowledge to better protect their children's health;

(b) To upgrade the knowledge and skills of all health workers in preventing and managing the most common causes of childhood mortality and morbidity;

(c) To provide supplies and equipment to enable health workers to utilize their training in preventing mortality and morbidity and improving service delivery;

(d) To support monitoring, evaluation and operational research activities in target areas.

34. UNICEF is presently funding a major study to collect information on the current activities of village community workers and their capacity to undertake further health work. Based on that study, UNICEF will assist the Government in formulating a plan to revitalize the workers by improving supervision and support, retraining and re-equipping existing workers and expanding the number to cover more areas. While village community workers will be the main focus, other village-level workers may also be assisted with training, educational materials or other inputs. One of the first steps will be to collect data on the experience of NGOs and other groups with community workers and to plan for the long-term sustainability of any new efforts.

35. With the current economic situation in Zimbabwe, efforts need to be made in the short term to better utilize available resources by all levels of the health sector, and in the long term to find ways to generate additional finances without placing an undue burden on the poorer sectors of society. In the spirit of the Bamako Initiative strategy, UNICEF will support research and pilot projects in community management and the financing of health units and other avenues for increasing revenues in order to provide directions for the Government on appropriate policies and strategies.

36. In order to maintain high coverage of immunization and achieve disease reduction targets, the following activities will be implemented:

(a) Improving coverage in low-coverage areas. National staff will work with provincial and district officials to resolve problems in areas where coverage is significantly below the national average;

(b) Improving disease surveillance and control, especially for neonatal tetanus and polio, through existing support under other UNICEF projects to the Epidemiology and Disease Control Department of the Ministry of Health;

(c) Purchasing polio vaccines and syringes, needles and sterilizers;

(d) Supporting the cold-chain system through the procurement of replacement cold-chain equipment, spare parts and supplies;

(e) In-service training of personnel in the cold chain and other EPI techniques.

37. CDD and control of ARI activities will include:

(a) Strengthening case management to reduce mortality;

(b) Educational activities for parents to enable them to identify signs of severity;

(c) Producing and distributing IEC materials for use at the community level;

(d) Preventing diarrhoea through hygiene education and better maintenance of water supplies;

(e) Operational research into alternatives for the sugar and salt solution.

38. The Ministry of Health is currently finalizing its plan to strengthen the national malaria control programme. UNICEF will support specific activities including:

(a) Training of community- and rural-based health workers in correct case management;

(b) Pilot projects on acceptability and appropriate channels for the distribution of insecticide-impregnated bed nets or cloths and similar forms of mosquito control;

(c) Support, including drugs, for testing the feasibility of chemoprophylaxis for pregnant women.

39. To reduce maternal and perinatal mortality, the basic strategy will be to improve access to and the quality of antenatal and post-natal care for mothers and children. To this end, the following safe motherhood activities will be pursued:

(a) To train traditional midwives to identify high-risk pregnancies for referral and to provide better delivery care for low-risk women who prefer to deliver at home;

(b) To provide basic equipment for rural health facilities and community-level workers to improve the monitoring of pregnancies and deliveries;

(c) To improve communications between rural health centres and referral centres;

(d) To conduct evaluation and operational research to identify areas for specific interventions.

40. UNICEF support for improving child nutrition will include:

(a) Addressing micronutrient deficiencies in the short term through the provision of vitamin supplements, notably iodine and vitamin A, to vulnerable populations;

(b) Supporting the National Nutrition Unit and other relevant bodies to develop a national nutrition policy in order to establish a framework to promote measures leading to household food security;

(c) Supporting community-organized preschool/child-care facilities;

(d) Expanding growth monitoring to the village level through training, equipping and supervising community workers.

41. The water supply and sanitation project will concentrate on expanding the role of existing water point committees to make them more responsible for water supply development and maintenance, health education and micro-environmental protection. In an effort to focus health education activities, environmental health technicians will identify risk behaviours associated with the most serious local water-associated diseases and plan activities in conjunction with the construction schedule.

42. This project will aim to complement services and activities already under way by the Government and NGOs with the support of UNICEF or other donors.

43. Supplementary funding in the amount of $9,289,000 is requested for the period 1993-1996 to support the above activities.

Estimated annual expenditure
(In thousands of United States dollars)

Country/programme	1993	1994	1995	1996	Total
Côte d'Ivoire					
Making health facilities "baby-" and "mother-friendly"	402	318	325	198	1 243
Guinea					
Basic education	275	250	200	-	725
Zimbabwe					
Support for child mortality reduction strategies	1 862	2 652	3 298	1 477	9 289
Total	2 539	3 220	3 823	1 675	11 257